Collaborative Working in Health and Social Care:  
A Review of the Literature

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Introduction

The move towards collaborative working in Health and Social Care can be situated within a wider policy shift associated with de-institutionalisation and de-segregation (Payne, 1995). The change from institutional to community-based care (Barr et al., 1999; Sibbald, 2000) meant that the demarcations and hierarchical relations between professions were neither sustainable not appropriate. New ways of working that crossed professional boundaries had to be created, in order to allow a more flexible approach to care delivery (Malin et al., 2002).

Collaboration in health and social care is a relatively new field of study, with the first major studies being undertaken in the 1980s (Roy, 2001). The term collaboration has hitherto lacked a clear definition and has been used synonymously with terms such as co-operation, co-ordination, participation and integration. Since the implementation of the 1990 NHS and Community Care Act (Department of Health, 1990), the concept has featured prominently in government policy documents to promote joint working, partnership and the creation of a ‘seamless service’ between health and social care (Maxwell, 1998; Payne, 1995). More recently, the term ‘communities of practice’ (CoPs) has permeated professional agendas (Lave and Wenger, 1991; Anning 2001). At its simplest the concept of collaboration infers that people from different professional and academic backgrounds form a working relationship for the purpose of enhanced service provision. However, the exact nature of the partnership is likely to be contested, whilst fully integrated ‘joined-up’ collaborative practice has so far proved elusive.

The term ‘collaborate’ derives from the Latin *com* which means ‘together’ and *laborare* which is ‘to work’, giving the meaning of ‘co-labour’. This leads to two potentially conflicting positions, one being ‘to work in partnership with others’ as defined in the Oxford Dictionary; the other being ‘to collaborate with an enemy’ (Forbes & Fitzsimmons, 1993). Hinds (1999) declares that this duality reflects tensions that are inherent in any endeavour where the situation is essentially dynamic. The terminology is more important for its place within practice than for what it may mean in the abstract (Bacchi, 2000). The meaning is not derived from language, but rather from its practical application in institutional settings, power relations and social positions (Ball, 1990).

Collaborative working has been seen as the ‘common sense’ approach to providing primary health care (Denton, 1997). Jones asserts that ‘Such discourse has popular appeal and has
achieved hegemonic status, going largely unchallenged, widely welcomed and subject to scant unbiased analysis (2000, p. 1). Mawhinney (1993) argues that if past efforts are taken into account, sustained collaboration among organisations will raise many issues around control, power and communication. Richards et al. (2000) and Sibbald (2000) acknowledge that little research has been conducted in this area.

By the 1990s several regulatory bodies required evidence of skills in collaborative working as part of their undergraduate programmes. These included the United Kingdom Central Council (UKCC), now the Nursing and Midwifery Council (NMC), the General Medical Council (GMC), the Council for Professions Supplementary to Medicine (CPSM), and the General Social Care Council, which regulates the education and training of social workers (now GSCC and TOPPS) (UKCC, 2001 p31). These bodies put pressure on course boards to include collaboration in the curriculum (Becher & Kogan, 1980), in order to meet the sponsorship requirements of the NHS at both Government and Trust level.

Following the election of New Labour in 1997, a ten-year programme of modernisation for the NHS was outlined with the government not only promising a commitment to collaborative working, but then giving it a decisive boost by making it a central plank of welfare reform. A clear expression of this can be found in NHS Plan (DH, 2000), Modernising the Social Services (DH, 1998a) and recently Our Health, Our Care, Our Say (DH, 2006). The imperative to create a culture of collaboration has been emphasised on professional training programmes, to ensure that diverse groups of staff could work collaboratively. UK universities have recognised that better shared learning was required (Whitehead, 2001), but new initiatives have tended to reinforce market-like behaviour (Becher & Trowler, 2001).

This paper will focus first on reviewing government policy, then on references to collaboration within the professional literature, and finally, reviewing the research evidence on partnership working in health and social care. It will conclude by examining the implications for professional education and training.

**Government policy**

Collaborative working has been part of government rhetoric for some time, and attempts have repeatedly been made to clarify its meaning. Caring for People (DH, 1989) asserted that successful collaboration required a clear, mutual understanding by every agency of each others’ responsibilities and powers, in order to make plain how and with whom collaboration should be secured. The paper then introduced the notion of a mixed economy of care which encouraged choice and flexibility, eventually leading to the conception of the NHS and Community Care Act (DH, 1990) with reference to a need for collaborative working, with overlapping roles between health and social care professionals. In 1995 A Vision for the Future (DH, 1995) called for health professionals to work together towards a common purpose, and in 1996 Choice and Opportunity (DH, 1996) highlighted various options for a new approach to the delivery of primary health care.
The notion of partnership working entered the lexicon of the policy maker about this time. The Primary Care Act 1997 (DH, 1997) highlighted seven areas for action, amongst which was partnership working. In the consultation paper Working Together to Safeguard Children (DH, 1998b), the Government built on Working Together Under The Children Act 1989 (HMSO, 1991) where guidance was issued to provide a solid foundation for inter-agency collaboration in child protection work, as ministers such as Frank Dobson at the Department of Health, believed that more needed to be done to break down barriers between professions. In Partnership in Action (DH 1998b) the Government declared that training and education were important in order to support and develop competencies for collaborative working.

New Labour’s ‘third way’ approach to policy reform, about how to balance the freedom of the market with a commitment to social justice (Stepney, 2000), promotes collaborative working as the cornerstone for the delivery of more effective services. This is emphasised in Our Healthier Nation: Saving Lives (DH, 1999a) and the Health Act (DH, 1999b), which require the NHS to strengthen partnerships with Local Authorities in order to develop more flexible approaches to the operationalisation of services. New opportunities were highlighted in Making a Difference: Strengthening the Nursing, Midwifery and Health Visitor Contributions to Health and Welfare (DH, 1999c) which meant that health care staff would be better able to utilise their skills and knowledge. Making a Difference suggests that NHS staff will need to work differently as the context of care changes, and it goes on to state that the Department of Health will take a lead role in assuring the quality of education provided for the NHS by universities. These changes were not unique to health, as it was made clear to social services that health and social services would be required to work in a more collaborative way, by the White Paper Modernising Social Services (DH, 1998c) and then Modernising Health and Social Services (DH, 1999d).

The broader vision of collaboration featured prominently in the new NHS Plan (DH, 2000). This was intended to create a service designed around the patient acknowledging that considerable reform and investment would be required. The plan reflected New Labour’s ‘third way’ political discourse and suggested that better prevention and health promotion offered a cost effective way to reduce health inequalities and tackle social exclusion.

The NHS Plan re-emphasised the importance of partnership working and expressed concern at the slow pace of change, suggesting that a radical redesign of the whole care system was being considered. At present only a relatively small number of patients appear to be benefiting from partnership working (Wistow, 2000a). The NHS Plan identifies old-fashioned demarcations between staff and barriers between services. These demarcations hold back staff from fulfilling their true potential, although ‘…throughout the NHS the old hierarchical ways of working are giving way to more flexible team working between different clinical professionals.’ (DH, 2000, p 82). However, Wistow points to the lack of emphasis on prevention and the development of healthy communities within the Plan. The Plan ignores the responsibilities that social services have for promoting social inclusion, and places them in a subordinate role to health aligned to NHS rehabilitation services (Wistow, 2000b).
The vision of fully integrated services could have been realised by the creation of Primary Care Trusts. However, Government drew back from proposing that the NHS should swallow the community care function of local authorities, including children's services, leaving proposals that related specifically to older people.

By July 2001 the Department of Health had produced *Shifting the Balance of Power within the NHS*, which focused on devolving power to frontline staff so that they could influence how services developed (DH, 2001a). Also, *Delivering the NHS Plan* (DH 2002) called for a radically different relationship between health and social services to fundamentally change the way that jobs were designed and work organised. Finally, *Our health, Our Care, Our Say* (DH, 2006) emphasised partnership working, but situated this within a framework of patient choice, flexible services geared towards prevention and improved performance driven by greater competition. Here professionals will be required to use market mechanisms to achieve a balance between competition and collaboration.

It is evident from the above that Government has been actively promoting collaborative working, and this is reflected in the professional literature. Hence, the policy climate and legislative backdrop were established to facilitate inter-agency and intra-agency collaboration. The stated aim has been to create high quality, needs-led, co-ordinated services that maximised choice for the service user (Payne, 1995). Stainton (1998) argued that although these goals were indeed admirable and desirable, there were few structural safeguards or guarantees. As disciplines move their boundaries, their power base shifts and as a result control may also shift (Gibbons, 1997).

**Professional documents**

Professional bodies both interpret, and have an influence on policy. Professional rhetoric is influenced by government policy and this has a substantial influence on what is included in the curricula for professional training.

In December 1994 the Minister for Health asked the Standing Medical and Standing Nursing and Midwifery Advisory Committees (SMNMAC) to consider how professionals from different disciplines working in a co-ordinated manner could enhance client care. The study found that ‘the importance of cross-boundary collaboration is, unfortunately, illustrated most clearly by its failures’ (p7), particularly in child protection and mental health. The report concluded that ‘Professional collaboration between health and social care services is more important than ever, given the number of administrative boundaries …and the separate sources of funding.’ (SMNMAC, 1996 p3). More recently the failure to collaborate effectively was highlighted as one of many missed opportunities by the inquiry into the tragic death of Victoria Climbié (Laming, 2003).

Reports from the English National Board for Nursing, Midwifery and Health Visiting (ENB) and the UKCC demonstrate how government policy on collaboration is incorporated into professional rhetoric. The ENB report *Shared Learning and Clinical Teamwork: New directions in education for multiprofessional practice* mapped the extent of collaborative
learning within and between health and social care professionals. A key finding was the low self-esteem of nursing staff compared to doctors or therapists. The report went on to state that it was no good providing training to facilitate interactive, multi-professional learning if the curriculum was not set up for such learning (ENB, 1999). The report identified the importance of giving students good role models in their clinical practice and fostering multi-professional environments of collaborative practice (ENB, 1999).

The report *Fitness for Practice* (UKCC, 1999) asserts that historical status differentials among nursing, midwifery, medicine and other health and social care professionals create rigid role boundaries which have a negative effect on collaborative working. The requirements in *Fitness for Practice and Purpose* for collaborative working were underpinned by the *Code of Professional Conduct* (UKCC, 1992), which required nurses and health visitors to:

…work in a collaborative manner with health care professionals and others involved in providing care, and respect their particular contributions within the care teams. (item 6)

The *Scope of Professional Practice* (UKCC, 1992) liberated the development of nursing, midwifery and health visiting practice, moving away from reliance on certificates towards accepting that tasks should be limited only by a practitioner’s own knowledge and competence. In a follow-up study many examples were given of nurses either expanding or changing their role (UKCC, 2000).

By 2000 "Several regulatory bodies require evidence of skills in collaborative working as part of their undergraduate programmes, including NMC, GMC, CPSM, GSCC and TOPPS" (UKCC 2001: 31). Further, the Quality Assurance Agency for Higher Education has included collaborative working as one of the benchmarking statements for health visiting students:

‘A3: Personal and professional skills of the health visitor: to work collaboratively with other health care professionals in professional practice.’

This ensures that academics become more publicly accountable for the work they do and demonstrates that the control of higher education is shifting away from an academic oligarchy towards more state control (Enders, 2001).

Although the merits of collaboration have rarely been disputed, the risk of conflict between the professional groups remains. Government is aware that professional groups are suspicious about the motives behind collaboration, and has attempted to address this through policy. The proposed measures are there ‘…to remove constraints in the system, introduce new incentives and update the collaborative arrangements’ (Pitkeathley, 1999, p 34). Using the analogy of the ‘Berlin Wall’ Pitkeathley argues that professionals have used innovative approaches to climb the wall on the basis of their own authority, rather than Government policy.
Professional cultures influence collaborative working in so far as they exclude and dominate others. Tierney (1987) argues that cultures are constructed as well as enacted, that people will change the culture within a professional organisation and not simply act it out. Hall and Weaver (2001) found that:

‘Professionals came to the health care team with preconceived maps of their roles based on their learned culture, beliefs and cognitive approaches…resulting in poor understanding of other people’s roles or maps, which may then cause conflict and anxiety in practice.’ 

(Hall & Weaver, 2001, p 871).

This links to Lave and Wenger’s (1991) work on Communities of Practice (CoP), that affect the way that a group uses knowledge. Wenger (1998) stated that CoPs could define the competence needed to practice as a professional. As CoPs aim to create and maintain a shared purpose and vision (Lathlean, 2002) they may be the ideal vehicle to move forward collaborative working.

Leiba states that 'Professional cultures which are shaped by long tradition and where specialists skills are practised, can become enclaves where like-minded people reinforce shared perceptions and sustain working methods unresponsive to a changing environment.' (1999, p 6). Whilst this may apply to stalwarts from the medical and legal profession, social work and nursing appear to have embraced collaboration more enthusiastically.

‘In order for teams to work effectively, there must be a process based on shared goals and philosophies, mutual respect, trust, a willingness to share knowledge, adapt, manage change, communicate openly and to take on board the realities of status, authority and power differentials.' (Leiba, 1996, 9). Further, it is necessary to be confident in one's own professional knowledge base, and to respect the knowledge base of other colleagues (Clatworthy, 1999).

Barr and Shaw suggest that there is evidence that 'College-based shared learning…improves reciprocal perceptions between professions and, by inference, predisposes participants towards collaborative practice.' They also suggest that ‘Work-based shared learning can have an immediate impact upon service development, organisational change and collaborative practice.' (Barr & Shaw, 1995, p 5). We now examine research evidence on collaboration from the field of professional practice.

**Research evidence from health and social care**


1. The developmental model, where staff work alongside each other and collaborate for the common good;
2. The contingency view, where collaboration is highly situational and will be influenced by structures, work demands, professional rituals and the qualities of the staff involved.

Research by Øvretveit (1993) and Lymbery (1998) suggests that hitherto the contingency view has been the more dominant. The major barriers were found to be different incentives rather than personality clashes. Recent research has shed some light on what is required for effective collaboration at the health/social care interface. Rummery & Glendinning (1997) focussed on seven projects where primary health and social services staff were working together to produce integrated services, both in general practice and for individual patients.

**Barriers to collaboration** were found to be:
- different resource allocation systems
- different accountability structures
- professional tribalism
- pace of change
- spending constraints

**Advantages**
- better understanding of the constraints of each agency and system overall
- shared information on local needs
- reduction in duplication of assessments
- better planning
- avoiding the ‘blame culture’ when problems occurred
- accessing social care via health less stigmatising

**Disadvantages**
- if commissioning was led by health, an over-emphasis on health care needs
- inequities between patients from different practices

Lymbery (1998) devised a framework for joint working and suggested that three perspectives shape practice outcomes:

1. Structural/organisational
2. Professional/cultural
3. Inter-professional

Successful joint working was achieved when each of these perspectives was addressed and was facilitated by the appointment of experienced staff (Lymbery, 1998).

In a study by Carpenter et al (2003) concerning the impact on staff of providing integrated care in multi-disciplinary mental health teams in the North of England, the most positive results were found in areas where services were fully integrated. However, surprisingly, the degree of service integration did not appear to have much bearing on job satisfaction or staff stress. What also emerged from the study was that social workers unlike their health
colleagues ‘…perceived their teams as being less participatory, gave lower ratings for team working, and experienced higher role conflict’ (p 1098). These findings about multi-professional teams replicate findings from other studies (see Onyett et al, 1997; Peck and Norman, 1999) and they also highlight the need for better role clarity and staff support.

Finally, Anning (2004) found that where practitioners from different CoPs come together, their different work cultures may mean that scenarios in practice will have different meanings affected by their various beliefs and professional knowledge. Anning emphasised the importance of collaborative learning in developing an understanding of the values and beliefs, and valuing the knowledge of professions other than one’s own.

**Conclusion**

The development of collaborative working will undoubtedly require a change in culture and values amongst health and social care professionals. According to Callwood ‘Research suggests that there are many difficulties in trying to combine distinct service cultures and knowledge into new ways of working at the interface with users’ (2003, p 12). It can be seen from this review that it is hard to isolate a single policy document to demonstrate how it influences collaboration in practice, because the documents are contextualised through other documents. This is in line with Ball’s (1990) view that a response to policy has to be constructed in context and then offset against other expectations, and this requires creative social action rather than robotic reactivity.

At a policy level, collaborative working has gained the status of being ‘…the common sense approach …the joined up solution to the joined up problem’ (Callwood, 2003, p 2) and thus becomes ‘naturalised’ as part of an ideology of collaboration. For it to become a reality, collaboration requires mutual trust, honesty and openness; and common understanding needs to replace tribalism and self interest.

Whilst policy may utilise the language of collaboration, it can be shaped by the economic interests of the agencies involved. From the literature it appears that one of the main drivers for collaborative working has been the need to increase the efficiency and effectiveness of health care. Part of this efficiency index is that collaboration between health professionals has been linked with positive outcomes for patients (Sundin-Huard, 2001).

There is much evidence to suggest that collaboration represents an ethical method of practice where differences are respected, but used creatively to find solutions to complex problems. This concurs with Gray’s vision of collaboration as,

‘…a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible.’

(Gray, 1989, p5).
However, a number of barriers and in-built resistance may have to be overcome; for example, social workers will need to overcome role conflicts in multi-disciplinary teams (Carpenter et al, 2003), and nurses will need to throw off an ‘alleged misogyny intrinsic to oppression theory and …stop acting as insidious gatekeepers to an iniquitous status quo’ (Farrell, 2001, p 32).

Collaboration in community care contains in-built tension, and research carried out in the hospital discharge of older people, demonstrates the danger of allowing managerial and market principles to shape decisions about long term care (Ford and Stepney, 2003). Collaborative practice has much to offer but does not fit into a policy climate of cost containment and targeting. Similarly, some studies have revealed that status and salary differentials inhibit professional collaboration and this will need to be addressed at both national and local level.

A number of different scenarios for the future can be constructed, and here Wistow (2000b) sets out a number of options. The optimistic vision is of inter-professional collaborative practice and partnership working supported by a properly funded system of care, creating seamless services provided though the new Care Trusts. Perhaps the most pessimistic and telling is that funding will be inadequate and the old ‘Berlin Wall’ divisions and mistrust will continue between social work and health professionals and between nurses and doctors: in other words, ersatz collaboration to meet government inclusion targets masquerading as genuine collaboration. In this scenario there is a danger of a return to more rigid, institutional, styles of practice rather than seeking creative and collaborative solutions. The most likely outcome will be something in between these two extremes, where collaborative practice will be increasingly influenced by the market to meet the diverse needs of practitioners and patients in different cultural contexts.

References


